NOTTINGHAM CITY COUNCIL

HEALTH SCRUTINY PANEL

MINUTES of the meeting held at Loxley House on 29 MAY 2013 from 1.30pm to 3.25pm

✓	Councillor Ginny Klein	(Chair)
✓	Councillor Thulani Molife	(Vice-Chair)
✓	Councillor Mohammad Aslam	
✓	Councillor Merlita Bryan	
✓	Councillor Azad Choudhry	
	Councillor Georgina Culley	
✓	Councillor Rosemary Healy	
✓	Councillor Brian Parbutt	
	Councillor Wendy Smith	
	Councillor Timothy Spencer	

✓ indicates present at meeting

Colleagues, partners and others in attendance:

Maria Principe	)	Nottingham City Clinical Commissioning Group	-	Director of Primary Care Development and Performance
Jo Williams	)		-	Programme Manager, Integrated Care
Carol Foster	)	CityCare Partnership	-	Locality Manager
Rosemary Galbraith	)		-	Assistant Director of Quality and Safety and Deputy Director of Nursing
Jane Garrard	)	Resources	-	Overview & Scrutiny Co-ordinator
Catherine Ziane-Pryor	)		-	Constitutional Services Officer

1 APPOINTMENT OF VICE-CHAIR

RESOLVED to appoint Councillor Thulani Molife as Vice-Chair for the 2013-14 municipal year.

2 APPOINTMENT OF LEAD HEALTH SCRUTINY COUNCILLOR

Jane Garrard informed the Panel that, in accordance with the Panel's terms of reference a Lead Health Scrutiny Councillor was required to liaise with stakeholders on behalf of the health scrutiny function, including the Health and Wellbeing Board, HealthWatch Nottingham, and the Portfolio Holder with responsibility for health and social care issues.

RESOLVED to appoint Councillor Ginny Klein as Lead Health Scrutiny Councillor for 2013-14 municipal year.

3 APOLOGIES FOR ABSENCE

Councillors Georgina Culley, Wendy Smith, and Timothy Spencer - all on other Council Business.

4 DECLARATIONS OF INTERESTS

None.

5 MINUTES

The Panel confirmed the minutes of the meeting held on 28 March 2013, as a correct record and they were signed by the Chair.

6 HEALTH SCRUTINY PANEL TERMS OF REFERENCE

Jane Garrard Overview and Scrutiny Co-ordinator, presented the report of the Head of Democratic Services which informed the Panel of the Terms of Reference which were agreed at Annual Council on 20 May 2013.

RESOLVED to note the Health Scrutiny Panel Terms of Reference.

7 'COMMUNITY CASE FINDERS' HOSPITAL DISCHARGE

The Panel considered the report of the Head of Democratic Services about the introduction of the 'community case finders' approach to improving hospital discharge.

Carol Foster, CityCare Partnership Locality Manager, informed the Panel of the progress of the scheme which, integrating with community based services, aimed to facilitate timely discharge of patients from hospital to their own homes. She highlighted the following points:

(a) Of the 146 patients that had so far been assessed under this approach , 41 were admitted to interim care, 105 were managed in the community, and 2 were directed to short-term care placements while the most appropriate care was identified.

(b) The role of the Clinical Inreach Workers is working well with community knowledge of available health and social care services proving valuable. Posts were initially on a secondment basis but recruitment to 2 substantive posts had now been undertaken. In addition, following the encouraging success of the scheme so far, further posts will be added creating a team of 8 based at Queens Medical Centre.

(c) A significant aspect of current work is streamlining pathways to avoid duplication of roles and integration into the wider work of Nottingham University Hospitals NHS Trust to improve hospital discharge.

(d) Due to the recent introduction of the 'community case finders' approach no patient feedback has been received so far. Currently there is no route for specific

feedback, but it is predicted that it will be routed via existing patient feedback channels.

(e) There are differences between social care provided in the City and the County (patients at the Queens Medical Centre come from, and return to, both areas) and this is expected to be highlighted by patient experience.

The responses to the Panel's questions included:

(f) Patients with carers at home made the transition from hospital to home much easier but it is important to link them with existing community based services such as emergency home care, crisis care and short-term placements so that they have appropriate support;

(g) 'Community casefinders' does not refer to Lings Bar Hospital, but GPs and other clinicians are still able to refer patients directly;

(h) The 'community casefinders' team operates between 8am and 10pm including weekends and bank holidays;

(i) The City established the Crisis Rapid Response Team two years ago, initially as a one year pilot to help keep patients in the community where possible. Once referred, patients were generally seen within 4 hours. Initially there was a team of 7 people and this number has now increased to 30;

(j) Patients and their families are asked what they want to best support their needs;

(k) No significant problems in sharing information between organisations have yet been identified but there is scope for improvement as this is still a fairly new arrangement;

(l) Given that services are provided by several organisations in an integrated way patient feedback needs to be combined into one request for feedback to simplify the process and prevent duplication. A challenge will be in clarifying which service patients are referring to when responding.

8 ADULT INTEGRATED CARE PROGRAMME

The Panel considered a report of the Head of Democratic Services summarising the key drivers for integrating adult health and social care and work that was taking place in Nottingham under the Adult Integrated Care Programme.

Jo Williams, Integrated Care Programme Manger, delivered a presentation, which was submitted to the electronic agenda following the meeting.

The Panel was shown a short film of the story of 'Ada' demonstrating the negative impact on vulnerable individuals of disjointed service provision. The Panel was informed that there are plans to produce a further film with a focus on how better integrated services could effectively support older people's needs.

Jo Williams made the following points and responded to the Panel's questions as follows:

(a) Historically there had not been a wholly co-ordinated approach to providing services for older people. When additional funding had been available in different health care and social areas, additional services evolved, but this has resulted in fragmentation and some duplication.

(b) There are strong national and local drivers to simplify and improve services through better integration and co-ordination.

(c) With an aging population, it is predicted that the proportion of people with long term conditions and complex needs will increase.

(d) GPs have reported that, once diagnosed, people have found it hard to find the appropriate co-ordinated care.

(e) More work is needed to better co-ordinate person-focused care, including cross county and partner provision, for example for people who attend GP surgeries located in the County.

(f) The current provision needs to be simplified, rather than add another layer of services, and patient expectations managed.

(g) 'Independence pathways' are to be provided based on an individual's needs.

(h) Improved continuity of care is important and citizens need to feel informed and empowered to manage their own health and care needs.

(i) The Clinical Commissioning Group (CCG) has funded the majority of work which is expected initially to be cost intensive and funding has been obtained to pump-prime the process. It is unlikely that the Programme will result in identifiable cash savings but will enable health and social care services to better cope with future increases in demand and reduce future financial pressures.

(j) Financial challenges still exist, including the need to make efficiency savings, but if services pro-actively work together, they can be met.

(k) The CCG have written to all GPs asking them for information on the physical health needs of patients, to enable the CCG to prepare to help manage those health needs.

(l) One of the challenges is developing a single assessment that can be used and trusted by all professionals, instead of the current situation where each service individually assesses the individual's needs.

(m) It is important that care is centred around the individual and the views of both patients and their carers need to be listened to with regard to the patient's needs.

(n) There is not yet agreement on using a common shared language across all services but the need has been acknowledged and the current focus is on being 'jargon-free'. Cultural issues can take a long time to address.

(o) Implementation is due to commence in January 2014.

(p) The Programme only covers integration of adult health and social care but there is a similar process for child health and social care issues.

RESOLVED

(1) to include an update on the Adult Integrated Care Programme on the work programme for March 2014;

(2) to include integration of child health and social care on the Panel's future work programme.

9 CITYCARE PARTNERSHIP QUALITY ACCOUNTS 2012/13

The Panel considered the report of the Head of Democratic Services explaining the requirements for quality accounts, and including the CityCare Partnership's draft Quality Account 2012/13.

Rosemary Galbraith, Assistant Director of Quality and Safety and Deputy Director of Nursing, introduced the draft CityCare Partnership Quality Account 2012/13 and invited the Panel to comment. The Panel noted that any formal comment made would be included in the final Quality Account which was to be published by 28 June 2013.

She informed the Panel that, having been subject to an unannounced inspection by the Care Quality Commission in March 2013, CityCare Partnership was found to be meeting all the essential standards which include:

- respecting and involving people who use services;
- care and welfare of people who use services;
- safeguarding from abuse people who use services;
- supporting workers;
- assessing and monitoring the quality of service provision.

There were no compliance notices issued.

The areas targeted for improvement in 2013/14 broadly remain the same as the 2012/13 year. However, since 2012/13 there have been improvements in performance, changes in culture and awareness raised amongst staff about the importance of the issues.. Areas of improvement included:

(a) Further work on caring for those with dementia, including improvement of assessment tools which would help bring necessary information together. Dementia training is taking place with input from partners across the City. Recognising the symptoms of dementia is important and further training of the workforce (with targets for achieving this) is proposed for 2013/14. The Panel particularly commended CityCare Partnership on its focus on dementia.

(b) There are national standards to ensure that the needs of patients are met. CityCare Partnership have examined their own data and considered the possible

risks to ensure that safeguarding against 'Never events' is in place. This has included focus on medicine management, pressure ulcers, and areas of high risk.

(c) The increase in serious incidents was at least partly due to an increased drive to encourage incident reporting so that lessons are learned and measures are in place to prevent such issues arising in future. As a result, the workforce is more likely to report incidents and take responsibility for them. All incidents are investigated and the Patient Safety Committee considers any learning, making immediate changes where necessary. Where appropriate, the information gathered is shared with partners to enable them to put necessary preventative measures in place. Organisationally there is now greater openness and transparency.

RESOLVED to submit a comment for inclusion in the CityCare Partnership Quality Account 2012/13 following circulation to Panel members by email and agreement by the Chair. The comment would focus on the areas in which the Panel had engaged with CityCare Partnership during 2012/13 and reflect the Panel's support for the work relating to dementia.

10 WORK PROGRAMME 2013/14

Jane Garrard, Overview and Scrutiny Co-ordinator, presented the report of the Head of Democratic Services, outlining the Panel's work programme for 2013/14. The Chair noted that an update on adult integrated care and work to integrate child health and social care, both identified at this meeting, will be added to the work programme.

RESOLVED to agree the work programme as follows:

24 July 2013	• **HealthWatch Protocol** • **Public Health**
25 September 2013	• **Quality of Care in Care Homes (TBC)** • **CityCare Partnership Complaints**
27 November 2013	• **Care at Home (tbc)**
29 January 2014	• **CityCare Partnership Quality Account 2013/14**
26 March 2014	• **HealthWatch Nottingham** • **Health and Wellbeing Board and Joint Health and Wellbeing Strategy** • **Adult Integrated Care.**

11 DATES OF FUTURE MEETINGS

RESOLVED to meet on the following Wednesdays at 1:30pm
2013 – 24 July, 25 September, 27 November
2014 – 29 January, 26 March